Brain Injury Workgroup Minutes

Meeting #2
September 6, 2011, 10:00 am to 3:15 pm
State Historical Building
600 East Locust
Des Moines, IA 50319

MINUTES

Attendance

Workgroup members: Megan Hartwig/Chair, Jack Hackett/Co-Chair, Tom Brown, Katrina Carter Larson, Julie Fidler Dixon, Dave Johnson, Lisa Langlitz, Geoffery Lauer, Lisa Langlitz, Rep. Linda Miller, LeAnn Moskowitz, Ben Woodworth

Absent: Kay Graber, Michael Hall, Rhonda Jordal

Facilitator: Teresa Hay McMahon

Staff: Lonnie Cleland

Other Attendees:

- Jess Benson — Legislative Services Agency
- Sandy Ferguson — Harmony House
- Jessica Harder — Davis Brown Law Firm
- Jenny Schulte — Advocacy Strategies
- Brad Trow — House Republican Staff
- Annie Uetz — Polk county Health Services

Agenda

Agenda Topics:

The Chair and Co-Chair welcomed the group. Workgroup members introduced themselves. Lauer explained the tool Dropbox for the workgroup to post full documents. Workgroup members will be responsible for sending Hartwig the executive summaries or written summaries of these documents to post to the MHDS Redesign BI Workgroup website.

DEFINE THE CURRENT STATE OF BI SERVICES IN IOWA

Facilitator led a discussion on the current state of BI services in Iowa.The workgroup discussed the following:

1. Key needs not being met that must be met to succeed:
    - Mild acquired brain injury (including traumatic brain injury) that go "off the radar" despite severe outcomes.
    - Ability to provide more than basic medical care including (substance abuse treatment, occupational therapy, physical therapy and speech therapy).
    - Information sharing across agencies and systems.
    - Inability to overcome fragmentation of service options and funding.
    - Data on actual costs across systems (e.g., incarcerated individuals) cost/benefit.
    - Medicaid waiver fine tuning.
    - Education of *all* service providers.
    - Availability of provider training and technical assistance to all providers.
    - Vocational and long-term medical needs.

2. Internal and external forces that affect performance:
    - Adequate resources (money and providers)
    - Federal policy—guidance, mandates, etc.
    - Regional design

3. Critical leadership beliefs and areas of concern:
    - Lack of recognition of Brain Injury as a disability (inc. SF 525).
    - Policymakers' belief of costs associated with brain injury (cost/benefit imbalance).

SWOT (STRENGHTS/WEAKNESSES/OPPORTUNITIES/THREATS) ANALYSIS

The group participated in a SWOT analysis exercise and tied each point to one of the core areas identified in the first workgroup meeting. Some points overlapped more than one core area.

<u>Services</u>

Strengths	**Weaknesses**
• Iowa has a Brain Injury Waiver • System of Case Managers • Long-standing, well developed Brain Injury Association • Strong core of Brain Injury service providers • Neuro-Resource Facilitation • VA regional system & funding stream	• Funding cap for BI Waiver services • Lack of capacity to assess/identify BI • Complexity of Veterans system • BI survivor #'s increasing while service capacity is staying the same • Cultural Competencies • Offender exclusion from disability services when BI occurs in institution

Opportunities	Threats
• Federally-qualified health centers • Regional TBI teams • Neurobehavioral services added to Medicaid • Increased benefits counseling	• The variance in ability of survivors to recover • Lack of care providers (capacity) with increasing numbers of providers aging out (e.g., elderly parents are now taking care of middle aged survivors)

Linkages

Strengths	Weaknesses
• IDPH Federal HRSA grant & access to other states with grant • Capacity to seek alternate funding • Linkages between IDPH/DHS/BIAIA/DOC/Service Providers • Long-standing, well developed BIA • Capacity for effective collaboration • Iowa COMPASS	• Identification and tracking inadequate, esp. in high-risk populations • BI waiver waiting list-length & lack of eligibility pre screening • Different definitions of BI for registry and services in IA Code • Poor collaboration with Disability Rights Iowa
Opportunities	**Threats**
• Partnerships with nursing homes & VA • Co-occurring disorders collaboration • Other service industries (i.e., corrections, substance abuse, mental health) requesting assistance • DHS administrative change-R. Shults • Regional TBI teams • Connect existing state resources • Decrease contact time for BI survivors through the registry	• Incompatible reporting requirements (e.g., HRSA grant housed in Maternal and Child Health at the Federal level) • Lag time to contact BI survivors through BI registry • Stigma of state agency culture/perception • Intra-agency fragmentation at the state level—leadership changes can result in programs taking new directions • “Silos”

Policy/Funding

Strengths	**Weaknesses**
• Trauma registry • IDPH Brain Injury Advisory Council • Capacity for prevention, education and treatment • Long-term federal funding for capacity development • Capacity to seek alternate funding • Dedicated state funding stream for BI services (IAC 641Ch. 56) • Lead agency (IDPH) designated in IA Code • DOC willingness to work with community • Policy makers requesting input from BI community • Leadership willingness to change • BI included in state Olmstead plan	• Funding cap for BI waiver • Case management mandated within waiver dollars (reduces $ available to individuals) • Service selection limited by funding amounts • Institutional bias for funding (historically) • Proper identification of institutionalized individuals • BI waiver waiting list-length & lack of eligibility pre screening • BI providers lack ability to retain adequate funds to develop programs • BI not included in disability services • No BI division at DHS • Inadequate outcome-based reporting • Different BI definitions between registry and services in IA Code • Lack of helmet law • Inability to implement code language • Offender exclusion from disability when BI occurs in institution • Poverty-based system
Opportunities	**Threats**
• Federally Qualified Health Centers • Bundling of funding-allows common services • IME infrastructure—presumptive eligibility • Affordable Care Act • MHDS redesign—Consistency in provider standards & increased expectations • DHS administrative change-R. Shults • Medical community movement to view BI as a disease • Regional TBI teams	• Strength of nursing home lobby vs. BI provider lobby (for-profit vs. non-profit) • Federal deficit (likely Medicaid reduction) • Healthcare reform-many unknowns • Lack of commitment at federal level • Incompatible reporting requirements (e.g., HRSA grant housed in Maternal and Child Health at the Federal level) • Lack of BI infrastructure in state & federal government • Not attaining change in 2012 session

• Increasing federal $ draw-down with use of state $ • Diversifying revenue sources & dedicating funding • IME design (similar to ins. Company)-BI growth opportunity • Neurobehavioral services added to Medicaid • Increased benefits counseling for survivors	• Intra-agency fragmentation at the state level—leadership changes can result in programs taking new directions • Competition for limited funding • One-time fix vs. on-going evolution with CQI • Downsizing government and government services • Private insurance pushing survivors to Medicaid

Population (Survivors of Brain Injury)

Strengths	**Weaknesses**
• DOC willingness to work with the community • Central Registry for Brain Injury (start on identification)	• Identification & tracking inadequate, esp. high-risk populations • Small percentage of disability population i.d. • Proper i.d. of institutionalized individuals • Lack of capacity to assess/identify BI • Different BI definitions between registry and services in IA Code • Inadequate capture of youth sport related injuries • BI survivor #s increasing vs. capacity to serve
Opportunities	**Threats**
• BI registry providers chance for study and outreach • Decrease contact time for BI survivors through registry	• Incompatible reporting requirements (e.g., HRSA grant housed in Maternal and Child Health at the Federal level) • Lag time to contact BI survivors through the BI Registry • The variance in ability of survivors to recover • Lack of care providers (capacity) with increasing numbers of providers aging out (e.g., elderly parents are now taking care of middle aged survivors) • Stigma—lack of willingness to self identify BI

GAP ANALYSIS/IDENTIFICATION OF CRITICAL SUCCESS FACTORS

The group discussed gaps in the current system.

Gap	Critical Success Factors
Lack of awareness of and support for Brain Injury.	• Targeted funding for BI services • Adequate data collection, assessment and dissemination (ROI focus) • Data-based decision making • Common data points/systems/definitions
Safety net for immediate and on-going needs of BI survivors.	• Needs-based resource facilitation and/or case management and benefits counseling
Disconnect between assessed vs. perceived need of BI survivors.	• Core set of provider standards for BI (core competencies & linkages) • Decreased institutionalization, incarceration and hospitalization of BI survivors

PUBLIC COMMENT

There was no public comment.

NEXT STEPS

- Small group schedule time for conference calls.
- Review materials posted to Dropbox.
- Provide Megan with executive summaries or written summaries of materials to post to DHS redesign website.

COORDINATION WITH OTHER WORKGROUPS

The efforts of this workgroup will have overlay with other workgroups as details of the redesign unfold.

MEETING SUMMARY

All handouts from the meeting will be posted on the DHS MHDS website.
http://www.dhs.state.ia.us/Partners/MHDSRedesign.html

NEXT MEETINGS

9/27/11—United Way of Central Iowa: Review of best practices from identified sources.

10/11/11—United Way of Central Iowa: Draft preliminary best practices recommendations.

10/27/11—Polk County River Place—Finalize best practices recommendations.